

COMPLAINT INVESTIGATION PACKET

07/21/2016

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FROM INVESTIGATOR OR SURVEYOR: Marieta Smith

NAME OF FACILITY: BHC Fairfax North

LOCATION: Everett, WA

SURVEY TYPE: COMPLAINT

INTAKE #: WA00066862

CASE #: 2016-6486

SHELL #: BQEP11

STATE LICENSE #: 60492181

MEDICARE #: Click here to enter text.

Choose an Item. START DATE: 07/19/2016

END DATE: 07/19/2016

TEAM MEMBERS: Marieta Smith

NOTES OR COMMENTS: Click here to enter text.

SOD SENT DATE: 08/03/2016

POC RECEIVED DATE: 08/11/2016

POC APPROVED DATE: 08/12/2016

PROGRESS REPORT RECEIVED: Click here to enter a date.

ARCHIVE NOTES:

ARCHIVE DATE:

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Revised - 05/27/2011

Facility: BHC Fairfax Hospital North
Location: Everett, WA
License Number: 60492181
Medicare Number:
Case Number: 2016-6486
Complaint #: WA00066862
Shell #: BQEP11

Date(s) of Investigation: 7/19/2016
Investigator: Marieta Smith, RN, MN

Allegations:

1. While in the "7th floor lobby" waiting to be voluntarily admitted to BHC Fairfax North (BHC FN), a female patient attempted suicide by "lunging for a window". The patient's husband prevented her from falling through the window by catching her by the back of her belt. During the suicide attempt, the woman broke the window and sustained severe lacerations.
2. BHC Fairfax has not replaced the window and has covered it with plywood.
3. When a patient is admitted to BHC Fairfax, BHC FN contacts Providence Regional Medical Center, Everett to provide security.

Process:

The investigator conducted an on-site investigation at the hospital on 7/19/2016. The investigation included the following:

1. Observation
 - a. Tour of the unit
 - 1) Observation of hospital lobby area
 - 2) Observation of repaired window in lobby area
 - 3) Observation of repairs in progress on the unit,
 - b. Observation of a security staff member assisting during a patient/staff interaction
2. Staff Interviews
 - a. Unit charge nurse
 - b. Unit staff nurse
 - c. Nurse Manager
 - d. Performance Improvement/Risk Manager
 - e. Providence Regional Medical Center security lead worker
3. Review of facility policies and procedures
4. Review of quality improvement documents
5. Review of hospital's staffing matrix
6. Review of staffing levels for two weeks prior to the investigation
7. Review of patient injuries for the past 12 months
8. Review of invoice for security window installation
9. Review of security agreement with Providence Everett Medical Center

Summary of Findings:

1. The hospital responded appropriately to the patient identified in the complaint.
2. The hospital replaced the broken window.
3. The hospital's admission policies do not include the process for assessment of "Walk-In" patients by BHC FN staff members.
4. Hospital staff members are not following the hospital's "Walk-In" algorithm.
5. The hospital does not track patients who present to the lobby for admission.
6. Patients are sent to the Providence Everett Medical Center Colby Campus emergency department for medical evaluation if they present to the lobby for admission. They are not assessed for suicide risk and other safety concerns.

Conclusion:

1. Allegation #1 was substantiated. There were no violations of the private psychiatric hospital regulations.
2. Allegation #2 was not substantiated due to lack of evidence.
3. Allegation #3 was not substantiated. The allegation did not occur.
4. Other deficient practice was found related to assessment of patients prior to admission to the hospital.

Action:

A Statement of Deficiencies was written for deficiencies found per the Private Psychiatric and Alcoholism Hospitals regulations under Chapter 246-322 WAC. The hospital did not have a process for assessing patients who presented to the hospital for suicide risk and other safety concerns prior to directing them to a local hospital emergency department. A Plan of Correction was requested.